Student Health Insurance Waiver Policy:
(For Fall 2006 through Summer 2007)

OHSU mandatory student group health insurance policy makes possible a waiver under certain circumstances. A request to decline coverage from the University plan must show that the student's current insurance plan for which a waiver is sought meets the basic health coverage features of the university plan, i.e. to be approved it must be a plan open to all members of a group regardless of individual circumstances, including past medical history, race, ethnicity, gender, etc. And it must insure adequately against unanticipated medical costs at a minimum of one million dollars lifetime benefit. Evidence of the following would meet these criteria:

- Employer group coverage with a minimum lifetime benefit of not less than $1,000,000.00, where the insured is a spouse or a parent of the student, or the student's own employer group plan when the student is employed. (Employer group insurance is open to all in the group regardless of personal circumstances. Individual insurance requires a rating process of the individual before acceptance as a policyholder.)
- Coverage under Medicare, Medicaid, FHIAP, OMIP, or coverage under a Cobra plan that extends employer group coverage.
- A unique individual plan providing a minimum of $1,000,000.00 lifetime benefit that meets extenuating circumstances such as the following: the student with a permanent ongoing medical condition who would not qualify for insurance for that condition after graduating and terminating the required OHSU student group insurance, is requesting a waiver to keep a plan which is guaranteed renewable permanently as long as the premium is paid, but would be irrevocably lost if terminated to enroll in the OHSU student plan. (An individual plan qualifying under this third criterion must have no other contingencies other than payment of premium for guaranteed renewal. For example, if guaranteed continuing coverage is contingent upon not moving away from the current locality, then this plan would not qualify for the waiver. If the plan is a recently purchased plan it would not qualify. It must be a plan that has served the needs of this student for a substantial period of time prior to coming to OHSU.)

These criteria are subject to change on an annual basis, and changes will be announced to new and continuing students in the month of May each year. DEADLINES: All applications for waivers must be received in the OHSU Student Health Service office *before* the first day of the month in which a student's program starts, or *before* the first day of the month in which fall term begins each year; must include a signed and notarized affidavit; and must be reapplied for annually at each fall term (the same deadline). Applications which are not notarized and/or do not include the required documentation as indicated on the waiver application form will not be considered. *Applications received on or after the first day of the month, if approved, will not be effective until the beginning of the next month.*

Student Group Health Insurance Waiver Application and Affidavit

Deadline: Application must be received in the Student Health Service Office before the first day of the month in which your program starts if you are a new student; Or before the first day of the month in which the insurance is to be effective if you are a continuing student. Annual re-applications are due before the first day of the month in which fall term begins.

Fall, Winter, Spring, Summer Terms 2006-2007
If Approved This Waiver Expires at the end of Summer Term, 2007

Student Name____
SS#: ____
Email address of student to notify re: decision_______________________________________
Phone number:_______________________________________
Date of application: ____
OHSU degree or certificate program: __________________
Campus you register on_______________________________
Training start date: _______________; expected graduation date: _____________________
Date received in Student Health Service: ____

Major Medical Insurance—Required for All Students
I hereby request to decline enrollment into the mandatory OHSU student group health insurance in favor of continuing my current alternative health insurance plan. If this waiver is approved, I certify that I will maintain this insurance and if it is terminated will notify OHSU in less than 30 days of such termination. I am requesting this waiver on the basis of one of the following three choices. (Check one):

❑ I. Employer group coverage with a minimum lifetime benefit of not less than $1,000,000.00, where the insured is a spouse or a parent of the student, or the student's own employer group plan when the student is employed.

Required documentation:
Name of insurance company: ____
Address of insurance company: ____
Phone number of insurance company: _______________________________________
Group policy number: _________________________ID#____________________________
Name of employer: ____
Name of primary insured: ___________________________________DOB_______________
Your relationship to primary insured: ____
Attach schedule of benefits showing lifetime maximum benefit of at least $1,000,000.00.
Attach a copy of your insurance card.

❑ II. Coverage under Medicare, Medicaid, FHIAP, OMIP, or coverage under a Cobra plan that extends employer group coverage.

Required documentation:

If enrolled in a private insurance plan under one of the above programs, list the following:
Name of insurance company: ____
Address of insurance company: ____
Phone number of insurance company: _______________________________________
Policy number: ______________________________ID#________________________
Name of primary insured:____________________________________DOB__________
Attach proof of current eligibility and enrollment in one of above covered programs.

☐ III. Coverage under an individual health insurance plan providing a minimum of $1,000,000.00 lifetime benefit where there are extenuating circumstances such as the following: the student with a permanent ongoing medical condition who would not qualify for insurance for that condition after graduating and terminating the required OHSU student group insurance, is requesting a waiver to keep a plan which is guaranteed renewable permanently if not terminated, but would be irrevocably lost if terminated to enroll in the OHSU student plan.

Required documentation:
Name of insurance company: ____
Address of insurance company: ____
Phone number of insurance company: _______________________________________
Date of inception of this policy: ____
Policy number: _______________________________ID#_______________________
Name of employer: ____
Name of primary insured: ________________________________DOB_____________
Your relationship to primary insured: ____
Attach a *statement from insurance company* that current policy is guaranteed renewable on a permanent basis with no exceptions except non-payment of premium.
Attach *schedule of benefits* showing lifetime maximum benefit of at least $1,000,000.00.
Attach narrative explanation of extenuating circumstance:
____
____

Dental Insurance – All Programs except School of Nursing LaGrande Campus; School of Dentistry; and 3rd year School of Pharmacy.
I hereby certify that I will maintain employer group dental insurance with the following company:
Insurance Company: __________________________ Address: ___________________________________
Phone: _______________ Name of Primary Insured: ____________________________DOB__________
Group Policy # ___________________ID#____________________________________

Vision Insurance-- All Programs except School of Nursing LaGrande Campus; School of Dentistry; and 3rd year School of Pharmacy.
I hereby certify that I will maintain employer group vision insurance with the following company:
Insurance Company: __________________________ Address: _____________________________________
Phone: _______________ Name of Primary Insured: _____________________________DOB__________
Group Policy # ___________________ID#_____________________________________

I understand that this application and affidavit will not be considered without appropriate documentation, and that I am subject to sanctions up to and including permanent dismissal from the university for intentionally providing misinformation in this document.

I understand that if this waiver is approved, it will expire at the start of the next Fall term and I must re-apply before it expires if I wish to continue this exemption from the required student insurance.

I understand that the insurance premium for the entire term will appear on my tuition account and it may take two weeks to have refunds credited after the waiver application is approved.

I affirm that the statements in this affidavit are true to the best of my knowledge:

Dated: ____

Signature

____

Name

____

Address

____

City, State, Zip code

Sworn before me this____________ day of __________________, 20_____

____

Notary

A student who loses waivered insurance during the school year must, within 30 days, enroll in the OHSU student group plan or be approved for a new waiver for a different qualifying plan

Address: OHSU Student Health Service, Mail Code: L587
3181 SW Sam Jackson Park Road, Portland, OR 97239
Phone: (503) 494-8665 **FAX**: (503) 494-2958 **email**: askshs@ohsu.edu

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